STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G622	A. BUILDING 00 B. WING	11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES-ADEPT	7520 KILMER LN INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for investigation of complaint #IN00118998. Complaint #IN00118998: Substantiated, Federal and state deficiencies related to the allegations are cited at W149, W153 and W183. Dates of Survey: November 28 and 29, 2012. Facility Number: 0001159 Provider Number: 15G622 AIMS Number: 100245690 Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/5/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 5 BDDS (Bureau of Developmental Disabilities Services) reports, the facility neglected to implement the facility's policy and procedure and neglected to immediately report inadequate supervision for 5 of 5 clients living in the group home (clients A, B, C, D and E). Findings include: On 11/28/12 at 11:27 AM the facility's BDDS Reports and investigations were reviewed from 09/01/12 through 11/27/12 and indicated a BDDS report for clients A, B, C, D and E which contained the following information: 10/30/12: Report submitted to BDDS for an incident dated 10/27/12 at 4:20 PM. The report indicated, "Staff reported that at 4:20 pm on 10/27/12, up on (sic) his arrival to [name] Group Home that he knocked and rang door bell several times and received no answer. After several attempts, [client B] (Individual Supported by [agency]) answered the door. After entering the house it appeared that the two staff on duty were asleep. Consumers did	W0149	**W 149 CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically, the direct support employee who failed to report immediately that he discovered two co-workers sleeping is currently suspended. Prior to returning to work, the employee will receive written corrective action and retraining regarding reporting expectations. **PREVENTION:** All facility professional staff will receive be provided with clear expectations regarding reporting, follow-up for all required incidents. Facility staff will be retrained regarding agency reporting procedures, with emphasis on timely completion. Retraining will focus on the need to immediately report all observed or suspected violations regardless of perceived level of severity. Staff will receive a clear understanding of the agency's organizational chart to facilitate reporting if the immediate supervisor is not available. The Quality Assurance and Operations Teams will monitor compliance with reporting timelines and coordinate corrective measures as needed. **RESPONSIBLE PARTIES:**	12/29/2012

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	not suffer any adverse emotional or physical reaction to the event and all consumers Healthcare Representative (sic) were notified. Plan to Resolve: [name], QMRP (Qualified Mental Retardation Professional), will train all staff on reporting incidents in a timely manner. Staff was suspended pending investigation." The investigation related to the 10/27/12 incident was reviewed on 11/28/12 at 11:35 AM and indicated the following: "Date and Time Incident allegedly occurred: Saturday, 10/27/12, 4:00 PM. Date and Time incident reported to facility personnel: Monday, 10/29/12, 11:40 AM. Person reporting incident: [staff #1]. Date and Time Investigator assigned to case 10/29/12, 11:40 AM. Nature of Allegation/Information provided at time of Investigator assignment: [Staff #1] reported to [name] RM (Residential Manager) and [name] QMRP that when he reported to work at [name] group home on Saturday, 10/27/12, at 4:37 PM, he observed [staff #2] and [staff #3] asleep in the living room. No other staff were on duty in the home at the time...Conclusion...8. The evidence substantiates that [staff #1] failed to report immediately allegations of neglect on Saturday, 10/27/12...Recommendations: 1. Term		QDDPD, Team Leader, Support Associates, Operations Team, Quality Assurance Team	

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	(terminate) [staff #2] for sleeping; 2. Term [staff #3] for sleeping...3. Retraining and written correction action for [staff #1] for failure to report immediately allegation of neglect...". On 11/28/12 at 2:50 PM, a review of the facility's 09/14/07 Policy on "Abuse, Neglect, Exploitation" indicated, "Adept employees actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported the the appropriate authorities...All employees will be trained on detection, reporting and prevention of abuse, neglect and exploitation...and will be trained on the types of incidents that are reportable to BDDS...The incident types are: Suspected abuse, neglect or exploitation...Inadequate staff support...". On 11/28/12 at 12:01 PM an interview with the Operations Manager (OM) was conducted. The OM indicated staff failed to follow the policy/procedure as they failed to report the incident immediately to the supervisor/administrator and the clients were unsupervised for an unknown period of time. The OM indicated staff #2 and staff #3 had been terminated. This federal tag relates to complaint			

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	#IN00118998. 9-3-2(a)			

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W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 5 of 5 BDDS (Bureau of Developmental Disabilities Services) reports, the facility failed to immediately report inadequate supervision for 5 of 5 clients living in the group home (clients A, B, C, D and E), in accordance with state law. Findings include: On 11/28/12 at 11:27 AM the facility's BDDS Reports and investigations were reviewed from 09/01/12 through 11/27/12 and indicated a BDDS report for clients A, B, C, D and E which contained the following information: 10/30/12: Report submitted to BDDS for an incident dated 10/27/12 at 4:20 PM. The report indicated, "Staff reported that at 4:20 pm on 10/27/12, up on (sic) his arrival to [name] Group Home that he knocked and rang door bell several times and received no answer. After several attempts, [client B] (Individual Supported by [agency]) answered the door. After entering the house it appeared that the two	W0153	**CORRECTION:** *The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.* Specifically, the direct support employee who failed to report immediately that he discovered two co-workers sleeping is currently suspended. Prior to returning to work, the employee will receive written corrective action and retraining regarding reporting expectations. **PREVENTION:** All facility professional staff will receive be provided with clear expectations regarding reporting, follow-up for all required incidents. Facility staff will be retrained regarding agency reporting procedures, with emphasis on timely completion. Retraining will focus on the need to immediately report all observed or suspected violations regardless of perceived level of severity. Staff will receive a clear understanding of the agency's organizational chart to facilitate reporting if the immediate supervisor is not available. The	12/29/2012

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	staff on duty were asleep. Consumers did not suffer any adverse emotional or physical reaction to the event and all consumers Healthcare Representative (sic) were notified. Plan to Resolve: [name], QMRP (Qualified Mental Retardation Professional), will train all staff on reporting incidents in a timely manner. Staff was suspended pending investigation." The investigation related to the 10/27/12 incident was reviewed on 11/28/12 at 11:35 AM and indicated the following: "Date and Time Incident allegedly occurred: Saturday, 10/27/12, 4:00 PM. Date and Time incident reported to facility personnel: Monday, 10/29/12, 11:40 AM. Person reporting incident: [staff #1]. Date and Time Investigator assigned to case 10/29/12, 11:40 AM. Nature of Allegation/Information provided at time of Investigator assignment: [Staff #1] reported to [name] RM (Residential Manager) and [name] QMRP that when he reported to work at [name] group home on Saturday, 10/27/12, at 4:37 PM, he observed [staff #2] and [staff #3] asleep in the living room. No other staff were on duty in the home at the time...Conclusion...8. The evidence substantiates that [staff #1] failed to report immediately allegations of neglect on Saturday,		Quality Assurance and Operations Teams will monitor compliance with reporting timelines and coordinate corrective measures as needed. **RESPONSIBLE PARTIES:** QDDPD, Team Leader, Support Associates, Operations Team, Quality Assurance Team	

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	10/27/12...Recommendations: 1. Term [staff #2] for sleeping; 2. Term [staff #3] for sleeping...3. Retraining and written correction action for [staff #1] for failure to report immediately allegation of neglect...". On 11/28/12 at 12:01 PM an interview with the Operations Manager (OM) was conducted. The OM indicated staff failed to report the incident immediately to the supervisor/administrator and the clients were unsupervised for an unknown period of time. This federal tag relates to complaint #IN00118998. 9-3-2(a)			

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W0183	483.430(c)(2) FACILITY STAFFING There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: (i) Clients for whom a physician has ordered a medical care plan; (ii) Clients who are aggressive, assaultive or security risks; (iii) More than 16 clients; or (iv) Fewer than 16 clients within a multi-unit building. Based on observation, record review, and interview for 5 of 5 clients (clients A, B, C, D and E) with behavioral needs, the facility failed to provide sufficient direct care staff on duty and awake to provide staff supervision for clients A, B, C, D and E. Findings include: On 11/28/12 at 11:27 AM the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 09/01/12 through 11/27/12 and indicated a BDDS report for clients A, B, C, D and E which contained the following information: 10/30/12: Report submitted to BDDS for an incident dated 10/27/12 at 4:20 PM.	W0183	**CORRECTION:** There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing Specifically, the two employees who were found to be asleep on 10/29/12 have been terminated. **PREVENTION:** All staff will be retrained on the requirement to remain awake and alert at all times, providing continuous active treatment as appropriate. In addition to conducting at least one morning and one evening active treatment observation, facility supervisory staff will conduct unannounced drop-in visits to the facility at varied times and days -including weekends, to assure staff are awake and alert. Members of the	12/29/2012

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	The report indicated, "Staff reported that at 4:20 pm on 10/27/12, up on (sic) his arrival to [name] Group Home that he knocked and rang door bell several times and received no answer. After several attempts, [client B] (Individual Supported by [agency]) answered the door. After entering the house it appeared that the two staff on duty were asleep. Consumers did not suffer any adverse emotional or physical reaction to the event and all consumers Healthcare Representative (sic) were notified. Plan to Resolve: [name], QMRP (Qualified Mental Retardation Professional), will train all staff on reporting incidents in a timely manner. Staff was suspended pending investigation." The investigation related to the 10/27/12 incident was reviewed on 11/28/12 at 11:35 AM and indicated the following: "Date and Time Incident allegedly occurred: Saturday, 10/27/12, 4:00 PM. Date and Time incident reported to facility personnel: Monday, 10/29/12, 11:40 AM. Person reporting incident: [staff #1]. Date and Time Investigator assigned to case 10/29/12, 11:40 AM. Nature of Allegation/Information provided at time of Investigator assignment: [Staff #1] reported to [name] RM (Residential Manager) and [name] QMRP that when he reported to work at		Operations and Quality Assurance teams will also conduct unannounced visits to the facility no less than monthly. **RESPONSIBLE PARTIES:** QDDPD, Team Leader, Support Associates, Operations Team, Quality Assurance Team	

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	[name] group home on Saturday, 10/27/12, at 4:37 PM, he observed [staff #2] and [staff #3] asleep in the living room. No other staff were on duty in the home at the time...Conclusion...1. The evidence substantiates that [staff #2] and [staff #3] slept while on duty on Saturday, 10/20/12...Recommendations: 1. Term [staff #2] for sleeping; 2. Term [staff #3] for sleeping...3. Retraining and written correction action for [staff #1] for failure to report immediately allegation of neglect...". Client A's record was reviewed on 11/28/12 at 12:15 PM. Review of the BSP (Behavioral Support Plan) dated 07/17/12 indicated client A had the following identified behaviors which included, but were not limited to: verbal aggression, delusions and physical aggression. Client B's record was reviewed on 11/28/12 at 12:30 PM. Review of the BSP dated 04/06/12 indicated client B had the following identified behaviors which included, but were not limited to: AWOL (absent without leave), self-injurious behavior and physical aggression. Client C's record was reviewed on 11/28/12 at 12:45 PM. The record did not			

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	contain a formal BSP (Behavioral Support Plan). The record indicated undated, "Behavioral Tracking" documents which indicated client C had the following identified behaviors which which were being tracked and included, but were not limited to: talking to self, hitting self, cursing and violating personal space/belongings. Client D's record was reviewed on 11/28/12 at 1:00 PM. Review of the BSP dated 05/31/12 indicated client D had the following identified behaviors which included, but were not limited to: self-injurious behavior, eloping and eating non-food items. Client E's record was reviewed on 11/28/12 at 1:15 PM. Review of the BSP dated 10/05/12 indicated client E had the following identified behaviors which included, but were not limited to: verbal aggression and physical aggression. On 11/28/12 at 12:01 PM an interview with the Operations Manager (OM) was conducted. The OM indicated staff should not have been sleeping and the clients should not have been unsupervised as their needs required staff supervision at all times. This federal tag relates to complaint			

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